

4963

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
c. LENGTH OF STAY IN 1b <u>40 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Valley</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WINNIE DAVIS ANGELL</u>				4. DATE OF DEATH <u>May 23 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hand-Suiter</u>		11. BIRTHPLACE (State or foreign country) <u>Tarboro Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Harner</u>				14. MOTHER'S MAIDEN NAME <u>Lydian Browne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-03-1089M</u>		17. INFORMANT <u>Henry H. Angell, Westminster Md RD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma intestinum</u> <u>153X</u> DUE TO <u>" "</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>" "</u> DUE TO <u>" "</u> (c) <u>" "</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>" "</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1956</u> , to <u>May 23, 1956</u> , that I last saw the deceased alive on <u>May 23, 1956</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Jernette</u> M.D.				DATE SIGNED <u>5-24-56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Carl Jernette MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminster Md</u>				24a. REC'D BY REGISTRAR <u>DATE 5-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 28 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04958

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>since 4-21-41</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore City</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3121 Wilkens Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Thomas Elmer Banks</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>12</u> Year <u>1956</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-4-1898</u>		<b>9. AGE</b> (In years last birthday) <u>57</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>Thomas F. Banks</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Myrtle Saunders</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unkn</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unkn</u>		<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>acute Pyelonephritis</u> (c) <u>944.7</u> DUE TO <u>Practure of neck of left humerus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>days</u>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Port II of item 18.)																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>James T Marsh</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>5/12/56</u>											
<b>EXAMINER'S NAME (Type)</b> <u>JAMES T MARSH</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>											
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 15, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Leadon Park Cem.</u>		<b>22d. LOCATION</b> (City, town or county) (State) <u>Balt. Maryland</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Truman Schuch</u>				<b>ADDRESS</b> <u>3512 Fredrick Ave.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>5/15/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Harry Stein</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City and County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint handwriting.

RECEIVED  
MAY 15 1956  
BUREAU V. S.





RECEIVED

MAY 15 1956

BUREAU Y. S.

1. NAME (Last, first, middle initial) [REDACTED]		2. SEX [REDACTED]	
3. DATE OF BIRTH [REDACTED]		4. PLACE OF BIRTH [REDACTED]	
5. OCCUPATION [REDACTED]		6. EDUCATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. RELIGION [REDACTED]	
9. PRESENT ADDRESS [REDACTED]		10. PREVIOUS ADDRESSES [REDACTED]	
11. SOCIAL SECURITY NUMBER [REDACTED]		12. SIGNATURE [REDACTED]	
13. DATE [REDACTED]		14. OFFICIAL USE [REDACTED]	

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

10-108-1

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4966

## CERTIFICATE OF DEATH

04960

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>310 E. Baltimore Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Merle</u> Middle <u>S.</u> Last <u>Baumgardner</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 24, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Franklin Baumgardner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>E. Elwood Baumgardner, Taneytown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Few Min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocarditis and Myocardial Degeneration</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/3</u> to <u>3/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>56</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. S. McVaugh</u>				ADDRESS (Street, city or town, state) <u>49 Frederick St. Taneytown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				DATE SIGNED <u>6/1/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Luss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>June 3, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Edhel M. Mehring</u>	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5 1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Diabetes Mellitus		Natural		Home		JAN 6 1956		10:15 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Phone	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's Zip		Medical Examiner's Phone	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's City		Coroner's State		Coroner's Country		Coroner's Zip		Coroner's Phone	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	
Burial Place		Burial Date		Burial Time		Burial City		Burial State		Burial Country		Burial Zip		Burial Phone	
St. Mary's Cemetery		JAN 6 1956		10:15 AM		St. Mary's		Baltimore		Maryland		21201		(410) 555-1234	

BUREAU V. 8

JUN 6 1956

RECEIVED

Handwritten signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4967

## CERTIFICATE OF DEATH

Reg. Dist. No.

04961

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN TB <b>10Y 7M 20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>4301 Arizona Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle Last <b>BERTRAND</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/18/86</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bricklayer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Bertrand</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Bertrand</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Record, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute massive hemorrhage</b> <b>452x</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>perforated arteriosclerotic aneurysm</b> (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b> <b>unknown</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic fibrous pulmonary tuberculosis</b> <b>Schizophrenic reaction, hebephrenic type</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/15</b> , 19 <b>52</b> , to <b>5/22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/22</b> , 19 <b>56</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DST</b> DATE SIGNED <b>5/22/56</b>							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/26/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Buck</b>				ADDRESS <b>5305 Harford Rd Baltimore</b>		24a. REC'D BY REGISTRAR DATE <b>5/23/56</b>	
						24b. REGISTRAR'S SIGNATURE <b>C. Harry Wilson</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

MAY 25 1956

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04962

Item 2, Film G198, 6/1/56 rcy

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>25Y 7 M, 28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MARGARET</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/25/99</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Lemmon</b>		14. MOTHER'S MAIDEN NAME <b>Viola M. Huson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>953.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Agranulocytosis</b> DUE TO (c) <b>Drug poisoning, Thorazine</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>16 days</b> <b>16 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/6</b> , 19 <b>56</b> to <b>May 22, 19 56</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>56</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 25, 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Krieders Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul A. Heemann</b>		24a. REC'D BY REGISTRAR <b>MAY 28 1956</b>	
ADDRESS <b>6067 Harford Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry [Signature]</b>	

RECEIVED

MAY 28 1956

BUREAU V. S.

4969 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

04963

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural WESTMINSTER</b>	
c. LENGTH OF STAY IN 1b <b>17 YRS.</b>		d. STREET ADDRESS <b>R.D. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IVY S. BROWN</b>		4. DATE OF DEATH <b>MAY 6 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 10, 1906</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>6</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CORNWALL</b>	
11. BIRTHPLACE (State or foreign country) <b>CORNWALL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN SLEEMAN</b>		14. MOTHER'S MAIDEN NAME <b>EDITH DINGLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NIO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>GEORGE A. BROWN</b>		Address <b>R.D. 4 WESTMINSTER, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of intestine</b> (b) <b>153X</b> (c) <b>12-13-55</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May, 1945</b> to <b>5-6-1956</b> , that I last saw the deceased alive on <b>5-8-1956</b> , and that death occurred at <b>1300 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. C. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster Md (E. Main)</b>	
PHYSICIAN'S NAME (Type) <b>Wm Carl Jarrette M.D.</b>		DATE SIGNED <b>5-8-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MAY 10, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Bankard</b>		ADDRESS <b>Son Westminster Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 5-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>H. Bankard</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. 3

MAY 14 1956

RECEIVED

CERTIFICATE OF DEATH

STATE OF NEW YORK

1956

4970

# CERTIFICATE OF DEATH

Reg. Dist. No.

04964

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3mos. 14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2707 Ashland Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Katharine</b> Middle <b>La</b> Last <b>BUCK</b>				4. DATE OF DEATH Month <b>5</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/31/88</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Skrabek Tailoring</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Langer</b>				14. MOTHER'S MAIDEN NAME <b>Katharine Rich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-09-6794A</b>			
17. INFORMANT <b>Record, Springfield State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Hepatitis, chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH <b>420.0</b> weeks <b>years</b> <b>months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral arteriosclerosis</b> <b>Chronic Brain Syndrome assoc. with senile brain disease, with psychosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/21</b> , 19 <b>56</b> , to <b>5/8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/8</b> , 19 <b>56</b> , and that death occurred at <b>3:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>5/8/56</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Sykesville, Maryland</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimmek Funeral Home, Inc.</b> ADDRESS <b>2601 E. Madison St</b>				24a. REC'D BY REGISTRAR <b>MAY 10 1956</b> 24b. REGISTRAR'S SIGNATURE <b>C. Harry Sharp</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

**RECEIVED**  
MAY 10 1956  
BUREAU V. 8

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. DATE OF DEATH May 10, 1956		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland	
10. OCCUPATION Retired		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SIGNATURE OF DECEASED None	
16. SIGNATURE OF WITNESS None		17. SIGNATURE OF PHYSICIAN None		18. SIGNATURE OF CORONER None	
19. SIGNATURE OF REGISTRAR None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF JURY None	
22. SIGNATURE OF JURY None		23. SIGNATURE OF JURY None		24. SIGNATURE OF JURY None	
25. SIGNATURE OF JURY None		26. SIGNATURE OF JURY None		27. SIGNATURE OF JURY None	
28. SIGNATURE OF JURY None		29. SIGNATURE OF JURY None		30. SIGNATURE OF JURY None	
31. SIGNATURE OF JURY None		32. SIGNATURE OF JURY None		33. SIGNATURE OF JURY None	
34. SIGNATURE OF JURY None		35. SIGNATURE OF JURY None		36. SIGNATURE OF JURY None	
37. SIGNATURE OF JURY None		38. SIGNATURE OF JURY None		39. SIGNATURE OF JURY None	
40. SIGNATURE OF JURY None		41. SIGNATURE OF JURY None		42. SIGNATURE OF JURY None	
43. SIGNATURE OF JURY None		44. SIGNATURE OF JURY None		45. SIGNATURE OF JURY None	
46. SIGNATURE OF JURY None		47. SIGNATURE OF JURY None		48. SIGNATURE OF JURY None	
49. SIGNATURE OF JURY None		50. SIGNATURE OF JURY None		51. SIGNATURE OF JURY None	
52. SIGNATURE OF JURY None		53. SIGNATURE OF JURY None		54. SIGNATURE OF JURY None	
55. SIGNATURE OF JURY None		56. SIGNATURE OF JURY None		57. SIGNATURE OF JURY None	
58. SIGNATURE OF JURY None		59. SIGNATURE OF JURY None		60. SIGNATURE OF JURY None	
61. SIGNATURE OF JURY None		62. SIGNATURE OF JURY None		63. SIGNATURE OF JURY None	
64. SIGNATURE OF JURY None		65. SIGNATURE OF JURY None		66. SIGNATURE OF JURY None	
67. SIGNATURE OF JURY None		68. SIGNATURE OF JURY None		69. SIGNATURE OF JURY None	
70. SIGNATURE OF JURY None		71. SIGNATURE OF JURY None		72. SIGNATURE OF JURY None	
73. SIGNATURE OF JURY None		74. SIGNATURE OF JURY None		75. SIGNATURE OF JURY None	
76. SIGNATURE OF JURY None		77. SIGNATURE OF JURY None		78. SIGNATURE OF JURY None	
79. SIGNATURE OF JURY None		80. SIGNATURE OF JURY None		81. SIGNATURE OF JURY None	
82. SIGNATURE OF JURY None		83. SIGNATURE OF JURY None		84. SIGNATURE OF JURY None	
85. SIGNATURE OF JURY None		86. SIGNATURE OF JURY None		87. SIGNATURE OF JURY None	
88. SIGNATURE OF JURY None		89. SIGNATURE OF JURY None		90. SIGNATURE OF JURY None	
91. SIGNATURE OF JURY None		92. SIGNATURE OF JURY None		93. SIGNATURE OF JURY None	
94. SIGNATURE OF JURY None		95. SIGNATURE OF JURY None		96. SIGNATURE OF JURY None	
97. SIGNATURE OF JURY None		98. SIGNATURE OF JURY None		99. SIGNATURE OF JURY None	
100. SIGNATURE OF JURY None		101. SIGNATURE OF JURY None		102. SIGNATURE OF JURY None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,7 Film 205 10-19-56 et

06008

4971

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 months 11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				d. STREET ADDRESS <b>1105 Fayette St., Baltimore</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWIN WARFIELD CHWEZUM alias CLARK</b>				4. DATE OF DEATH Month Day Year <b>May 30 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-15-87</b>	
9. AGE (In years last birthday) yrs. <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Chwezum</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bartlett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1918 577-22-9546</b>		17. INFORMANT <b>Mr. Russell Clark (Brother)</b>		Address <b>1214 Beechwood Road Sparrows Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic heart disease</b> DUE TO (c) <b>General arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's syndrome. C.B.S. due to cerebral arteriosclerosis &amp; poisons</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>March 16</b> , 19 <b>56</b> , to <b>May 30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 30</b> , 19 <b>56</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt</b>				DATE SIGNED <b>5/30/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight - Sykesville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>6/9/56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Allen</b>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4972

## CERTIFICATE OF DEATH

Reg. Dist. No.

04965

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN b <b>7 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Allegany 006</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route # 3 Keyser, W.V.</b> d. STREET ADDRESS <b>Route # 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Franklin</b> Last <b>Coleman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-94</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>27</b> Hours <b>19</b> Min. <b>56</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Coleman</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT <b>Anna Mae Preston (daughter)</b> Address <b>Route # 3 Keyser, West Virginia.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with disturbance of metabolism, growth or nutrition, presenile brain disease with psychotic reaction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-26-</b> , <b>1955</b> , to <b>May 27-</b> , <b>1956</b> , that I last saw the deceased alive on <b>May 27-</b> , <b>1956</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b> DATE SIGNED <b>5-27-56</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital.</b>		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/30/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rawson</b>	22d. LOCATION (City, town, or county) (State) <b>Rawson, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. C. Boul.</b> ADDRESS <b>Westport, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5/27/56</b>	24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4973 CERTIFICATE OF DEATH

06009

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SOLOMON</b> Middle Last <b>COOK</b>				4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/30/67</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Timberworker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ynk.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Cook</b>				14. MOTHER'S MAIDEN NAME <b>Martha Hagens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome due to cerebral arteriosclerosis, with psychosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5/27</b> , 19 <b>56</b> to <b>5/27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>56</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/28/56</b>							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Embalmed</b>				22b. DATE THEREOF <b>5/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Md. School of Medicine</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>				24a. REC'D BY REGISTRAR DATE <b>5/28/56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Allen</b>	

9561 51 NOV

RECEIVED

4974

## CERTIFICATE OF DEATH

Reg. Dist. No.

71

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> 63-yr.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hammon Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>BLANCHE</u> Last <u>DALEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1892</u>	
9. AGE (In years, last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife (floral, wholesale &amp; retail)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Austin J. Dutton</u>				14. MOTHER'S MAIDEN NAME <u>Alice Feaser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>220-34-58715</u>			
17. INFORMANT <u>Louise Daley Westminster Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of colon and</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases to liver</u> DUE TO (c) <u>Operation 11-55 for obstruction</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>about 8 mo.</u> <u>about 8 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 15, 1955</u> , to <u>May 4, 1956</u> , that I last saw the deceased alive on <u>May 2, 1956</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>5-4-56</u>							
ACTUAL SIGNATURE <u>C. E. Billigelson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Westminster Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster Md</u>				24a. REC'D BY REGISTRAR <u>DATE 5-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Bulley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

1956 8 17

RECEIVED

4975

CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Laura R. Dehoff</u>			4. DATE OF DEATH <u>May 30 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 18-1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuck</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13. FATHER'S NAME <u>John C. Rohrbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Arthur Dehoff</u>		Address <u>Greenmount Md</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial - chronic</u> DUE TO <u>arteriosclerosis</u> (c) <u>decompensated</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>✓</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Greenmount Carroll Md</u>	20f. CITY or town (County) (State)

21. I certify that I attended the deceased from <u>1-1-40</u> to <u>5-30-56</u> , that I last saw the deceased alive on <u>5-28-56</u> and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>James S. Saffell</u>	M.D. <u>Reisterstown Md</u>
PHYSICIAN'S NAME (Type) <u>James S. Saffell</u>	DATE SIGNED <u>5-31-56</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u>		24a. REC'D BY REGISTRAR <u>✓</u> 24b. REGISTRAR'S SIGNATURE <u>Reisterstown Md</u>	
ADDRESS <u>Hampstead Md</u>		DATE <u>5/31/56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4976

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04967

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b> c. LENGTH OF STAY IN 1b <b>life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. F. D. # 6</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b> d. STREET ADDRESS <b>R. F. D. # 6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Milton</b> Last <b>Ditman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. Const.</b>	11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Lewis Ditman</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Rosenberger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>George E. Ditman</b> Address <b>Westminster, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis &amp; Decomposition</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio sclerotic C-V disease</b> (c) <b>Arterio sclerotic C-V disease</b> DUE TO couple lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Days -</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 19, 56</b>	22c. NAME OF CEMETERY OR CREMATION <b>Deer Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Samllwood Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b> ADDRESS <b>Westminster, Maryland</b>		24a. REC'D BY REGISTRAR <b>5-19-56</b>	24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, giving the ward "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. S.



Reg. Dist. No. \_\_\_\_\_

## 4977

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		1880		MINNAPOLIS		MINNAPOLIS		Hennepin		MINNAPOLIS		MINNAPOLIS		Hennepin		MINNAPOLIS	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTY OF MARRIAGE		STATE OF MARRIAGE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Carpenter		High School		Married		Roman Catholic		1905		MINNAPOLIS		MINNAPOLIS		Hennepin		MINNAPOLIS		MINNAPOLIS		Hennepin		MINNAPOLIS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS		May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS		May 11, 1950		Home	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Heart Disease		Natural		May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS		May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS		May 11, 1950		Home		MINNAPOLIS		Hennepin		MINNAPOLIS		May 11, 1950		Home	

BUREAU V. S.

MAY 11 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4978

## CERTIFICATE OF DEATH

04969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>FRANKLIN</b> Last <b>ELY</b>				4. DATE OF DEATH Month <b>5</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/09</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Edward Franklin Ely</b>				14. MOTHER'S MAIDEN NAME <b>Nannie F. Pilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unk -</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>521X</b> IMMEDIATE CAUSE (a) <b>Multiple lung abscesses</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Acute cystitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>week or more</b> <b>week</b> <b>3 - 4 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to post-encephalitic Parkinsonism</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20f. (County)		20f. (State)	
21. I certify that I attended the deceased from <b>5/2</b> , 19 <b>56</b> , to <b>5/11</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/10</b> , 19 <b>56</b> , and that death occurred at <b>4:15A</b> <b>PST</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>5/11/56</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M. D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5/12/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>			

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MAY 14

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BUREAU V. S.

MAY 14 1956

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04970

4979

# CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Woodbine</i>		LENGTH OF STAY (In this place) <i>6 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		<i>03-52-2</i>	
TOWN				STREET ADDRESS (If rural give location) <i>15 Magruder Ave</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Weitzel Conv. Home</i>							
<b>3. NAME OF DECEASED</b> (First) <i>JOHN</i> (Middle) <i>CALVIN</i> (Last) <i>710HR</i>				<b>4. DATE OF DEATH</b> (Month) <i>MAY</i> (Day) <i>29</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>WIDOWED</i>	<b>8. DATE OF BIRTH</b> <i>8-10-1876</i>	<b>9. AGE last birthday</b> <i>79</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Retired</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>Jeremiah Flohr</i>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>John B. Flohr - 15 Magruder Ave</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE</b> (A) <i>Cerebral Hemorrhage, Coronary</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>28 May 56</i>			
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <i>Thrombosis, Arteriosclerosis.</i>				<i>29 May 56</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <i>CARDIAL failure</i>				<i>Sick from</i>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<i>Aug 55</i>			
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>9th</i>, 19<i>56</i>, to <i>May</i>, 19<i>56</i>, that I last saw the deceased alive on <i>29 May</i>, 19<i>56</i>, and that death occurred at <i>9:25 P.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Howard E. Hall</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Alexandria, Md</i> <b>DATE SIGNED</b> <i>29 May 56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>6/1/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Springfield Cemetery</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Lukeville - Md</i>	
<b>24. REC'D BY REGISTRAR</b> <i>4-56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Robert P. Heath</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mac Nabbs &amp; Son</i>		<b>ADDRESS</b> <i>Catonsville - 28</i>	





1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04971

4980

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u> TOWN <u>20 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> TOWN <u>Rural</u> STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Jesse L. Frock</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 2 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 27-1890</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra Frock</u>		14. MOTHER'S MAIDEN NAME <u>Laura Bixler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>210-30-0868</u>	
17. INFORMANT & ADDRESS <u>Della Frock Manchester Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis (recurrent)</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-12-47</u> to <u>5-2</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-30</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. H. F. F. F.</u>		DATE SIGNED <u>5-3-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Samuel Miller</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR <u>May 3-56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u>	
REGISTRAR'S SIGNATURE <u>Mrs W. F. Deener</u>		ADDRESS <u>Hampstead Md.</u>	

# CERTIFICATE OF DEATH

12

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF MINISTER

19. SIGNATURE OF CLERGYMAN

20. SIGNATURE OF RABBI

21. SIGNATURE OF PRIEST

22. SIGNATURE OF BISHOP

23. SIGNATURE OF ARCHBISHOP

24. SIGNATURE OF CARDINAL

25. SIGNATURE OF POPE

26. SIGNATURE OF DECEASED

27. SIGNATURE OF NEXT OF KIN

28. SIGNATURE OF BURIAL OFFICIAL

29. SIGNATURE OF CHURCH OFFICIAL

30. SIGNATURE OF MINISTER

31. SIGNATURE OF CLERGYMAN

32. SIGNATURE OF RABBI

33. SIGNATURE OF PRIEST

34. SIGNATURE OF BISHOP

35. SIGNATURE OF ARCHBISHOP

36. SIGNATURE OF CARDINAL

37. SIGNATURE OF POPE

38. SIGNATURE OF DECEASED

39. SIGNATURE OF NEXT OF KIN

40. SIGNATURE OF BURIAL OFFICIAL

41. SIGNATURE OF CHURCH OFFICIAL

42. SIGNATURE OF MINISTER

43. SIGNATURE OF CLERGYMAN

44. SIGNATURE OF RABBI

45. SIGNATURE OF PRIEST

BUREAU V. S.

MAY 7 1933

RECEIVED

4958

## CERTIFICATE OF DEATH

04972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN Ib <b>10 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 E. Green St.</b>		d. STREET ADDRESS <b>123 E. Green St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emogene Gladys Garner</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1894</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
13. FATHER'S NAME <b>John C. Main</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Stine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Scott Y. Garner</b> Address <b>Westminster, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7440 Suffocation following Paralysis of Muscles of Respiration -</b> DUE TO (b) <b>Myasthenia Gravis -</b> DUE TO (c) <b>6 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 years</b> INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Westminster</b>		20g. (County) <b>Carroll</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>January 1956</b> to <b>May 29, 1956</b> that I last saw the deceased alive on <b>May 29, 1956</b> , and that death occurred at <b>12-AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster, Maryland</b> DATE SIGNED <b>5/29/56</b>					
ACTUAL SIGNATURE <b>John R. Byers</b>		M.D. <b>Westminster, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>S. Luther Bare, M.D. 79 W. Main St. Westminster, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 30, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch</b>	
22d. LOCATION (City, town, or county) <b>near Westminster, Md.</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-31-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Harold Miller</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John C. Smith	
Sex		Male	
Age		10 years	
Date of Death		1954	
Place of Birth		Westminster, Md.	
Residence at Time of Death		123 E. Green St., Baltimore, Md.	
Cause of Death		Sudden death	
Occupation		Student	
Date of Birth		1944	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1954	
Place of Registration		Baltimore, Md.	

BUREAU V. 1

JUN 4 1954

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04973  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>6 mos 17 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore - 2</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural, give location) <u>823 Ashland Court</u>			
3. NAME OF DECEASED: (Type or Print) <u>Julia</u>		(First) (Middle) (Last) <u>GOOTEE</u>		4. DATE OF DEATH <u>5</u> <u>30</u> <u>19</u> <u>56</u>		(Month) (Day) (Year)	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 17, 1868</u>	9. AGE last birthday: <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Stevenson</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary Thrombosis</u>						<u>One hour</u>	
Antecedent cause(s) (b) <u>Cerebral sclerosis with probable</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Picks Disease</u>						<u>?</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture-neck left femur</u>						<u>3 weeks</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Heather Boerz</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5/30/56</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL (Specify): <u>Buried</u>		DATE THEREOF <u>June 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St Peter's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG. <u>6-1-56</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Earl B. Walberton Funeral Home Inc</u>		ADDRESS <u>6306 - Belair Rd, Baltimore-6, Md.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4982

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
c. LENGTH OF STAY IN 1b <u>59 yrs.</u>		d. STREET ADDRESS <u>568 Baltimore Blvd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR STEELTON GROFT</u>		4. DATE OF DEATH Month Day Year <u>May 3 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1896</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>yard man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Westminster Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Graft</u>		14. MOTHER'S MAIDEN NAME <u>Bliss Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>213-05-1707</u>	
17. INFORMANT <u>Mrs. Blanche L. Graft</u> Address <u>Westminster Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cordose disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1947</u> to <u>May 3 1956</u> , that I last saw the deceased alive on <u>Apr 28 1956</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. <u>Westminster Md.</u>		DATE SIGNED <u>5/5/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr.</u> ADDRESS <u>Westminster Md.</u>		24. REC'D BY REGISTRAR DATE <u>5-5-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Harold Paul</u>			

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
NAME OF DECEASED		NAME OF PHYSICIAN	
AGE		SEX	
DATE OF BIRTH		DATE OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		DATE	

BUREAU V. 3

MAY 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4983 CERTIFICATE OF DEATH

Reg. Dist. No.

04925  
74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 3 wks.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>John</b> Last <b>HEIM, Sr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>		9. AGE (In years last birthday) <b>65</b> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Stephen Heim</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Mentler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-03-1759</b>		17. INFORMANT <b>Springfield Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abscess of Pituitary gland</b> <b>446x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Suppurative nephritis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome, alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/3/56</b> , 19 <b>56</b> , to <b>5/24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/24</b> , 19 <b>56</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Walther H. Sonnenfeldt</b> <b>5/25/56</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Springfield State Hospital, Sykesville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons</b>		24. REG'D BY REGISTRAR <b>MAY 28 1956</b>	
ADDRESS <b>2024 Orleans St. 31</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Steen</b>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED JOHN J. BROWN		SEX MALE		DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BOSTON, MASS.	
OCCUPATION LABORER		MARRIED <input checked="" type="checkbox"/> YES		DATE OF MARRIAGE DEC 10 1910		PLACE OF MARRIAGE BOSTON, MASS.	
CAUSE OF DEATH HEART DISEASE		PERIOD OF ILLNESS 2 WEEKS		DATE OF DEATH MAY 10 1956		PLACE OF DEATH BOSTON, MASS.	
SIGNATURE OF PHYSICIAN J. J. BROWN		SIGNATURE OF REGISTRAR J. J. BROWN		SIGNATURE OF DECEASED J. J. BROWN		SIGNATURE OF WITNESS J. J. BROWN	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as reported to me by the attending physician and the family of the deceased.		REGISTERED J. J. BROWN		DECEASED J. J. BROWN		WITNESS J. J. BROWN	

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MAY 28 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04976

4984

## CERTIFICATE OF DEATH

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN STREET</u>		d. STREET ADDRESS <u>MAIN STREET</u>	
3. NAME OF DECEASED (Type or print) <u>LOUIS C HESS</u>		4. DATE OF DEATH <u>MAY 22 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 12 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS HESS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HARDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>ANNA B. HESS</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>578X</u> DUE TO <u>Intestinal Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ulcer</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/20 1956</u> to <u>5/22 1956</u> that I last saw the deceased alive on <u>5-22-1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>5-22-56</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 25 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY</u>		22d. LOCATION (City, town, or county) (State) <u>HAMPSTEAD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Hartzler</u> ADDRESS <u>Union Bridge</u>		24a. REC'D BY REGISTRAR DATE <u>5/24/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Philip D. Phelps</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WILLIAM J. HARRIS</i>		DATE OF DEATH <i>May 23 1956</i>	
AGE <i>65</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		RESIDENCE <i>1234 Elm St. Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
PLACE OF DEATH <i>Home</i>		CERTIFIED BY <i>Dr. J. H. Smith</i>	
DATE OF CERTIFICATE <i>May 24 1956</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	

BUREAU V. S.

MAY 23 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster RD #6</i>	
c. LENGTH OF STAY IN 1b <i>4 days</i>		d. STREET ADDRESS <i>East View</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glover's Boarding House</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BETTY</i> Middle <i>PEARL</i> Last <i>HILL</i>		4. DATE OF DEATH Month <i>May</i> Day <i>21</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1883</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Garden, Carroll Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Hoff</i>		14. MOTHER'S MAIDEN NAME <i>Martha Lockard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>M. Wm. C. Hill Westminster RD #6 Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO (c) <i>Diabetes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>4 yrs</i> <i>8 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>49</i> , to <i>May 21</i> , 19 <i>56</i> that I last saw the deceased alive on <i>May 29</i> , 19 <i>56</i> , and that death occurred at <i>12:10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. E. Wilkens</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>May 21 1956</i>	
PHYSICIAN'S NAME (Type) <i>EREESE WILKENS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 23, 56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Silver Run Carroll Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Murre, Jr.</i>		ADDRESS <i>Westminster Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Harold Miller</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1956

BUREAU V. A.

MAY 24 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4986

## CERTIFICATE OF DEATH

04978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 yr., 4 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2</b>			
f. STREET ADDRESS <b>Valley &amp; Biddle Streets</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Mary</b> Last <b>Hogarty</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not known</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Not known</b>							
13. FATHER'S NAME <b>John Hogarty</b>				14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchopneumonia Failure</b> <b>521X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Lung abscesses due to Septicemia</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>1 days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				(County) (State)			
21. I certify that I attended the deceased from <b>12-20</b> , 19 <b>54</b> , to <b>5-18-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-18-</b> , 19 <b>56</b> , and that death occurred at <b>3:18 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gertrud Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville Md</b>			
PHYSICIAN'S NAME (Type) <b>SONNENFELDT, Gertrud</b>				DATE SIGNED <b>5/18/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rita Wiedefeld</b>				ADDRESS <b>900 E. Biddle St</b>		24a. REC'D BY REGISTRAR <b>MAY 22 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>			

MEDICAL CERTIFICATION

**BUREAU V. S.**

MAY 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4987  
CERTIFICATE OF DEATH

04979

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>	c. LENGTH OF STAY IN 1b <u>301 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1919</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Odenton, Maryland</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-28-6717</u>	17. INFORMANT <u>Katherine Johnson - Odenton, Maryland</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral pulmonary TB, cavitation rt.</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 12</u> , 19 <u>55</u> , to <u>May 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 8</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>5-8-56</u> ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D. <u>Henryton, Maryland</u> PHYSICIAN'S NAME (Type) <u>Tom F. Vestal, M.D., Supt.</u> <u>Henryton State Hospital, Henryton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____		24a. REC'D BY REGISTRAR DATE _____	24b. REGISTRAR'S SIGNATURE <u>Albert R. Swankhouse</u>



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4959** **CERTIFICATE OF DEATH**

**04980**

Reg. Dist. No. **76**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CARROLL</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> c. LENGTH OF STAY IN 1b <b>30 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>92 W. GREEN</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>92 W. GREEN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>NANNIE LEE LEASE</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>MAY 14 1956</b> Month Day Year					
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-14-1887</b> 9. AGE (In years last birthday) <b>69 yrs.</b>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MD.</b>					
<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>BENJAMIN F. BREYER</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA MARTLYNN</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>					
<b>17. INFORMANT</b> <b>MARYLEE DUTTIER</b> Address <b>115 PA. AVE. WESTMINSTER</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>15 min 5+ yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that I attended the deceased from</b> <b>Jan 25, 1956</b> , <b>to</b> <b>5-14-1956</b> , <b>that I last saw the deceased alive on</b> <b>Feb 25, 1956</b> , <b>and that death occurred at</b> <b>MD.</b> , <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <b>DR. E. REESE WILKENS</b> <b>W.D.</b> <b>15 Kenner Westminster</b> <b>PHYSICIAN'S NAME (Type)</b> <b>DR. E. REESE WILKENS</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>22b. DATE THEREOF</b> <b>5-17-1956</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. UNION CEMETERY</b> <b>16 UNION BRIDGE MD.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. B. ANDERSON</b> <b>ADDRESS</b> <b>WESTMINSTER MD.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>5-18-56</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <b>H. B. ANDERSON</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 8

MAY 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
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1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4988  
CERTIFICATE OF DEATH

04981

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Springfield State Hospital</b>		d. STREET ADDRESS <b>10113 Big Rock Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15562	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>E.</b> Last <b>Lutz</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/11/68</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>2 Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-11 nk</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>4-nk</b>	
17. INFORMANT <b>Springfield Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 7</b> , 19 <b>56</b> , to <b>May 14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 14</b> , 19 <b>56</b> , and that death occurred at <b>2:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>5/14/56</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green</b>		22d. LOCATION (City, town, or county) (State) <b>Woodbury, N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Davis Funeral Home</b>		ADDRESS <b>Woodbury, N. J.</b>	
24a. REC'D BY REGISTRAR <b>DATE 5/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Ware</b>	

BUREAU V. S.

MAY 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4989  
CERTIFICATE OF DEATH

04982

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>43Y 10M 1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				d. STREET ADDRESS <b>unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADELAIDE MC KEE</b>				4. DATE OF DEATH Month Day Year <b>5 16 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/4/72</b>		9. AGE (In years last birthday) yrs. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Record, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic morphinism and paranoiac delusions</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Sykesville, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from <b>5/14/56</b> , 19 <b>56</b> , to <b>5/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/16</b> , 19 <b>56</b> , and that death occurred at <b>6:50P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>5/16/56</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwigson</b>				ADDRESS <b>2024 Orleans St</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Keays</b>			

MEDICAL CERTIFICATION

36

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4990 CERTIFICATE OF DEATH

04983

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>			
3. NAME OF DECEASED (Type or print) <u>HAZEL - W - MILLS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15 - 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas N Williams</u>				14. MOTHER'S MAIDEN NAME <u>Lottie Witter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-22-3966</u>			
17. INFORMANT <u>Miss Helen Houser, Manchester Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia Primary Supra</u> <u>200.1</u> DUE TO <u>Clavicular lymph node (B)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno Carcinoma of Cervix Uteri</u> (c) <u>6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 MCO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 5, 1950</u> to <u>May 20, 1956</u> that I last saw the deceased alive on <u>May 20, 1956</u> and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nevin H. Seitz M.D.</u>				ADDRESS (Street, city or town, state) <u>May 20 - 1956</u>			
PHYSICIAN'S NAME (Type) <u>NEVIN H. SEITZ M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Davids</u>		22d. LOCATION (City, town, or county) (State) <u>York Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton, Hampstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>May 22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. WPS. Denner</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4991

## CERTIFICATE OF DEATH

04984

Reg. Dist. No. 82-83

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgeville</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Nursing Home</b>		d. STREET ADDRESS <b>Mt. Airy</b>	
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>D.</b> Last <b>Moxley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1871</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Florence, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Greenbury Warfield</b>		14. MOTHER'S MAIDEN NAME <b>Druzanna Warthen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Gaver Moxley, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with</b> <b>151x</b> DUE TO <b>General Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 24, 1955</b> , to <b>May 26, 1956</b> , that I last saw the deceased alive on <b>May 25, 1956</b> , and that death occurred at <b>7:00</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. M. Van Pelt</b> ADDRESS (Street, city or town, state) <b>Mt Airy Md</b> DATE SIGNED <b>5-26-56</b> PHYSICIAN'S NAME (Type) <b>C. M. Van Pelt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Poplar Springs, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moleworth</b>		24a. REC'D BY REGISTRAR <b>Robert R. Huwitt</b>	
ADDRESS <b>Damascus, Md.</b>		DATE <b>May 27</b>	

28-1-1

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04985

Reg. Dist. No. 70

4992

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Taneytown</u> c. LENGTH OF STAY IN 1b <u>few hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>York</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> d. STREET ADDRESS <u>105 E. Hanover Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPH</u> First <u>F</u> Middle <u>MURPHY</u> Last				<b>4. DATE OF DEATH</b> <u>May</u> Month <u>19</u> Day <u>1956</u> Year											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 5, 1929</u>		<b>9. AGE</b> (In years last birthday) <u>26</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Long distance hauling</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Penna.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Nicholas Murphy</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Little</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____				<b>16. SOCIAL SECURITY NO.</b> <u>178-22-9389</u>		<b>17. INFORMANT</b> <u>Mr. Nicholas Murphy, 105 E. Hanover St. Hanover</u> Address _____									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>914.4</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Pa.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury, in Part I or Part II of item 18.) <u>Metal pole he was passing contacted live wire</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11</u> a.m. <u>5-19</u> <u>1956</u>				<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Tar Ground Taneytown Penna</u>				<b>20f. (City or town)</b> (County) (State) <u>Taneytown</u> <u>Carroll</u> <u>Pa.</u>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>James J. Marsh</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>5/19/56</u>			
<b>EXAMINER'S NAME (Type)</b> _____						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>May 22, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph's Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Hanover, Pa.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Dennis R. H. Wetzel</u>						<b>ADDRESS</b> <u>Hanover, Pa.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>May 21/1956</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Ethel M. Mahring</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MAY 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4993

## CERTIFICATE OF DEATH

04986

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL STATESVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTVIEW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PULLEN NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVA</u>		First Middle Last <u>NIGHTENGALE</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1893</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELSWORTH LOVELL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HAINES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GEORGE D. NIGHTENGALE</u> Address <u>Eastview, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carboc arrest, acute secondary anemia, 174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma uterus i generalized</u> DUE TO (c) <u>metastasis -</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1955</u> to <u>May 13, 1956</u> , that I last saw the deceased alive on <u>May 13, 1956</u> , and that death occurred at <u>10 A.M.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HOWARDE HALL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TRINITY LUTHERAN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>EASTVIEW MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Blandford</u> ADDRESS <u>Box WESTMINSTER, MD</u>				24a. REC'D BY REGISTRAR <u>5/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Tucker</u>	

BUREAU V. S.

MAY 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be filled in by the attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4960  
CERTIFICATE OF DEATH

04987

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>106 E. GREEN ST.</u>				d. STREET ADDRESS <u>106 E. GREEN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRESTON LINCOLN PHILLIPS</u>				4. DATE OF DEATH Month Day Year <u>MAY 15<sup>th</sup> 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 13, 1899</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CATTLE DEALER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEW WINDSOR, MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM THEODORE PHILLIPS</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA ALICE ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-18-5818</u>			
				17. INFORMANT Address <u>Mr. Preston L. Phillips, Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>May 12, 1940</u> , to <u>May 12, 1956</u> , that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. C. Smith</u> M.D. <u>105 E. Main</u>				ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>5-19-56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Carl Jarratte M.D. Westminster</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 15, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		22d. LOCATION (City, town, or county) <u>Burial Westminster, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE 5-15-1956</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

CERTIFICATE OF DEATH

1950

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-1-28		MOBILE, ALABAMA	
RACE		SEX		MARRIAGE	
WHITE		MALE		MARRIED	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
RELIGION		MANNER OF DEATH		PLACE OF DEATH	
METHODIST		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
5-4-68		10:00 AM		HOME	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY	
JAMES EARL RAY		3701 17th Ave S		MEMPHIS, TENN	
DECEASED'S STATE		DECEASED'S COUNTY		DECEASED'S ZIP	
MISSISSIPPI		DEKALB		38117	
DECEASED'S SOCIAL SECURITY		DECEASED'S MARITAL STATUS		DECEASED'S RACE	
1-345-67890		MARRIED		WHITE	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S RELIGION	
LABORER		HIGH SCHOOL		METHODIST	
DECEASED'S MANNER OF DEATH		DECEASED'S PLACE OF DEATH		DECEASED'S DATE OF DEATH	
NATURAL		HOME		5-4-68	
DECEASED'S CAUSE OF DEATH		DECEASED'S TIME OF DEATH		DECEASED'S PLACE OF DEATH	
HEART DISEASE		10:00 AM		HOME	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY	
JAMES EARL RAY		3701 17th Ave S		MEMPHIS, TENN	
DECEASED'S STATE		DECEASED'S COUNTY		DECEASED'S ZIP	
MISSISSIPPI		DEKALB		38117	
DECEASED'S SOCIAL SECURITY		DECEASED'S MARITAL STATUS		DECEASED'S RACE	
1-345-67890		MARRIED		WHITE	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S RELIGION	
LABORER		HIGH SCHOOL		METHODIST	
DECEASED'S MANNER OF DEATH		DECEASED'S PLACE OF DEATH		DECEASED'S DATE OF DEATH	
NATURAL		HOME		5-4-68	
DECEASED'S CAUSE OF DEATH		DECEASED'S TIME OF DEATH		DECEASED'S PLACE OF DEATH	
HEART DISEASE		10:00 AM		HOME	

BUREAU V. S.

MAY 16 1956

RECEIVED



4994

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snyderburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JOHN - G - REED</u> First Middle Last		4. DATE OF DEATH <u>May 22</u> Month Day Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 - 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmund Reed</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs John G Reed, Hampstead Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Colon</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>ninch</u> , 19 <u>50</u> , to <u>May 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>56</u> , and that death occurred at <u>12:05</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		DATE SIGNED <u>5/22/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton, Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Ms. HPS - Denver</u>	
ADDRESS		DATE <u>May 23/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 18

1956

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

4995

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Rural</u>		c. LENGTH OF STAY IN 1b <u>4 yrs 8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>135 N. Wolfe St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Schmidt</u> Last <u>Schmidt</u>		4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bakery seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>August Borchers</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Springfield State Hosp. Records</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 7, 1953</u> , to <u>May 11, 1956</u> , that I last saw the deceased alive on <u>May 11, 1956</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. N. Mastin</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>M. N. Mastin</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAY 14-56</u>	<u>HOLY REDEEMER</u>	<u>BELAIR RD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPEL BROS</u>		ADDRESS <u>1800 E. LOMBARD</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>E. J. H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1921		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER					
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
JAN 6 1968		MOBILE ALABAMA		HEART DISEASE		NATURAL		2 WEEKS		NONE		NONE		NONE	
CERTIFICATE OF DEATH		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		FILE NO.		DATE OF REPORT		REPORTED BY		SIGNATURE	
100-443886		100-443886		100-443886		100-443886		100-443886		100-443886		100-443886		100-443886	

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MAY 14 1956  
BUREAU Y. 3

CERTIFICATE OF DEATH

Reg. Dist. No.

74

4996

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN IB <b>2Y 6M, 12 D</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>OTTO WILLIAM SCHOLZ</b>				4. DATE OF DEATH Month Day Year <b>5 18 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/00</b>	9. AGE (In years last birthday) yrs. <b>55</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Berlin, Germany</b>	
13. FATHER'S NAME <b>Wilhelm Scholz</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1917 to 1921</b>				16. SOCIAL SECURITY NO. <b>216-03-8954</b>			
17. INFORMANT <b>Record, Springfield State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningo-encephalitis</b> <b>026X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lues</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with CNS syphilis, meningoencephalitic with psychotic reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>5/10</b> , 19 <b>56</b> , to <b>5/18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/18</b> , 19 <b>56</b> , and that death occurred at <b>1:42 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				DATE SIGNED <b>5/18/56</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>May 21, 1956</b>		<b>Baltimore National</b>		<b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl B. Wolbrun Funeral Home, Inc.</b>				24a. REC'D BY REGISTRAR <b>May 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>R. W. C. Thompson</b>	
ADDRESS <b>6306 Belair Rd, Baltimore 6, Md</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page One of Two

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARITAL STATUS		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAY 21 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04991

4997

## CERTIFICATE OF DEATH

Reg. Dist. No.

70

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>			
c. LENGTH OF STAY IN 1b <u>20 years</u>				d. STREET ADDRESS <u>Broad Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Grace</u> Last <u>Sell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22, 1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Fox</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Beecher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-4102</u>		17. INFORMANT Address <u>Mr. Clyde Sell, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Endocarditis &amp; High Blood Pressure</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 24, 1956</u> , to <u>May 6, 1956</u> , that I last saw the deceased alive on <u>May 5, 1956</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>5-8-56</u>			
PHYSICIAN'S NAME (Type) <u>T. H. Legg, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marwyn C. Fuss</u> ADDRESS <u>Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR <u>May 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Ethel M. Wehring</u>	

BUREAU V. S.

MAY 10 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4998**  
**CERTIFICATE OF DEATH**

**04992**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Caroline</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Raymond</u> Middle <u>Edward</u> Last <u>Seth</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>21</u> Year <u>1956</u>						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 14, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lumber</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ridgely, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Steven Seth</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Clinty Clark</u>						
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>213-01-7830</u>		<b>17. INFORMANT</b> Address <u>Beatrice Simpson - Ridgely, Maryland</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency; enlargement rt. aurricle &amp; Ventricle</u> <u>519.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Pleurisy &amp; infiltration left base - etiology undetermined</u> DUE TO _____ (c) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____		
<b>21. I certify</b> that I attended the deceased from <u>May 19, 1956</u> , to <u>May 21, 1956</u> , that I last saw the deceased alive on <u>May 21, 1956</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u> DATE SIGNED <u>5-21-56</u> ACTUAL SIGNATURE <u>T.F. Vestal</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Tom F. Vestal, M.D., Supt.</u> <u>Henryton State Hospital, Henryton, Maryland</u>										
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) _____			<b>22b. DATE THEREOF</b> _____		<b>22c. NAME OF CEMETERY OR CREMATORY</b> _____			<b>22d. LOCATION</b> (City, town, or county) _____ (State) _____		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> _____ ADDRESS _____					<b>24a. REC'D BY REGISTRAR</b> DATE <u>5-21-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Albert R. Swankhaus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—SALT MORE 18

BUREAU V. S.

MAY 22 1956 -

RECEIVED



Item 9, Film G198, 6/4/56 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R 3 Gist</b>		d. STREET ADDRESS <b>R 3 Gist</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>Shauck</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1864</b>
9. AGE (In years last birthday) <b>92 1</b> yrs.		IF UNDER 1 YEAR Months <b>17</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Months <b>17</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Brice Criswell</b>		14. MOTHER'S MAIDEN NAME <b>Sally Ann (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Hollis Criswell</b>		Address <b>R 3 Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial degeneration &amp; atherosclerosis</b> DUE TO (c) <b>arterio sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several yrs.</b> <b>several yrs.</b> <b>several yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> , to <b>May 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 15</b> , 19 <b>56</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. G. Speicher</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster Md</b> DATE SIGNED <b>5/18/56</b>	
PHYSICIAN'S NAME (Type) <b>W. G. Speicher, M.D. 135 E. Main St. Westminster, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 21, 56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE 5-19-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harriet Muller</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 22 1956

RECEIVED

5700

## CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snydersburg</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ESTIE - V - SIMMONS</u>		4. DATE OF DEATH <u>May 15</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22-1896</u>
9. AGE (In years last birthday) <u>60 yrs</u>		IF UNDER 1 YEAR: Months <u>6</u> Days <u>15</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Idella Alban</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Joe &amp; Simmons, Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive C.V. Disease</u> DUE TO (c) <u>17 years</u> <u>16 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 45</u> , 19 <u>56</u> , to <u>May 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>56</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>5/16/56</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		Hampstead, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Snydersburg</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Supton, Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 5/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Henry J. Kell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 18 1956

RECEIVED

VS. A15ME(S)  
SM 9/55



MISSOURI AND STATE DEPARTMENT OF HEALTH - BATHING 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 23 1956

RECEIVED

Items 14,3: film G197 5-15-56L **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miller Station Road</b>				d. STREET ADDRESS <b>Miller Station Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>D.</b> Last <b>Sparr</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7th</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1879</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Donnelly</b>				14. MOTHER'S MAIDEN NAME <b>? not known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Raymond Gonce, Miller Station Rd.</b>		Address <b>Manchester, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11</b> , 19 <b>55</b> to <b>5-7-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-7-</b> , 19 <b>56</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Manchester, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>W. H. Foard</b>			M.D. <b>Dr. W. H. Foard</b>				
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				ADDRESS		24a. RECEIVED BY REGISTRAR <b>MAY 10 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Mrs. H. R. L. Lerner</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 10 1956

RECEIVED

5703

## CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>MAIN STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA SNADER SPOERLEIN</u>				4. DATE OF DEATH Month Day Year <u>MAY 12 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>REV ABRAM P SNADER</u>				14. MOTHER'S MAIDEN NAME <u>MAY STOFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>RANDALL SPOERLEIN NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cervix Stage III c</u> <u>171x</u> DUE TO <u>metastasis + bilious obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arterio Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 MO</u> <u>7 MO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1955</u> to <u>May 12, 1956</u> that I last saw the deceased alive on <u>May 12, 1956</u> and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Lem Spiecher M.D.</u>				ADDRESS (Street, city or town, State) <u>Westminster, Md</u>		DATE SIGNED <u>5/13/56</u>	
PHYSICIAN'S NAME (Type) <u>W. G. Lem Spiecher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Hartzler &amp; Sons</u>				ADDRESS <u>New Windsor</u>		24a. REC'D BY REGISTRAR DATE <u>May 16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ernest E. Bunder</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 17 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>R. F. D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rhoda</u> Middle <u>Stanley</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fork Neck, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pender</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. ???</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Rhoda Stanley - Patient</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Insufficiency</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Diabetes</u> DUE TO (c) <u>Far advanced bilateral pulmonary tuberculosis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1-</u> , 19 <u>56</u> , to <u>5-4-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-4-</u> , 19 <u>56</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D. <u>Henryton, Maryland</u>		DATE SIGNED <u>5-4-56</u>	
PHYSICIAN'S NAME (Type) <u>Tom F. Vestal, M. D., Supt.</u> <u>Henryton State Hospital, Henryton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
ADDRESS		DATE	<u>Albert R. Swanphaw</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4961  
CERTIFICATE OF DEATH

04999

Reg. Dist. No. 713

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>155 W. Main Street</u>		d. STREET ADDRESS <u>155 W. Main Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>REESE</u> Last <u>Starnor</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Creamery worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin Starnor</u>		14. MOTHER'S MAIDEN NAME <u>Anna Circle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-22-1039</u>	
17. INFORMANT <u>Ralph D. Starnor, Westminster, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia.</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic Cardiovascular Renal Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>Years-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/10/51</u> , 19 <u>51</u> , to <u>5/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/29</u> , 19 <u>56</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Allen Moulton</u> G. ALLEN MOULTON, M.D. WESTMINSTER, MD.		DATE SIGNED <u>Westminster, Md. 5/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baust Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tyrone, Carroll, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Fusa</u> Paneytown, Maryland		24a. REC'D BY REGISTRAR DATE <u>6-2-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Harold Smith</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

JUN 5 1956

RECEIVED

Continuation of the death certificate form, including fields for medical history, autopsy, and certification. The form is partially filled out with handwritten text.

5905

## CERTIFICATE OF DEATH

Reg. Dist. No.

14

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3037 Hudson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Aloysius</b> Last <b>Staylor</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 - 24 - 91</b>	9. AGE (In years last birthday) yrs. <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Edward Staylor</b>				14. MOTHER'S MAIDEN NAME <b>? DILLAWAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with circ. dist. with cerebr. arterioscl. with</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT, WAS UNDER DRUGS, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-2-56</b> , 19 <b>56</b> , to <b>5-26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-25-56</b> , 19 <b>56</b> , and that death occurred at <b>9:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b> DATE SIGNED <b>5-25-56</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				SYKESVILLE, MD.			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>				Springfield State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-29-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM</b>		22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RP., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeller</b>				ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>		24a. REC'D BY REGISTRAR <b>MAY 28 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 TO FURNISHING: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

2005

BUREAU V. S.

MAY 29 1956

RECEIVED

5306

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
c. LENGTH OF STAY IN 1b <b>7 days</b>			d. STREET ADDRESS <b>1515 N. Bruce Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Lee</b> Middle <b>Steeple</b> Last <b>Steeple</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1879 ??</b>		9. AGE (In years last birthday) <b>76 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Janitor</b>	11. BIRTHPLACE (State or foreign country) <b>Howard Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Katie Steeples</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>??</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Lee Steeples - 1515 N. Bruce Street, Balto., Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X Cardio-vascular Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral cavitory pulmonary TB.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 15, 1956</b> , to <b>May 22, 1956</b> , that I last saw the deceased alive on <b>May 22, 1956</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>T. F. Vestal</b>		M.D. <b>Henryton, Maryland</b>		DATE SIGNED <b>5-22-56</b>	
PHYSICIAN'S NAME (Type) <b>Tom F. Vestal, M. D., Supt. Henryton State Hospital, Henryton, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>5-22-56</b>	24b. REGISTRAR'S SIGNATURE <b>Albert R. Swankhouse</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5007

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>Hobsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hobsville</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>J.</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21-1908</u>		9. AGE (In years last birthday) <u>47</u> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William A. Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Susie C. Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO. <u>220-01-4088</u>		17. INFORMANT <u>James A. Stewart</u>		Address <u>Sykesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>7 m.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/31/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery, Baltimore</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight</u> ADDRESS <u>Sykesville, Ind.</u>				24a. REC'D BY REGISTRAR <u>5/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Henry Weir</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only death is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05003

5908

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster, Md. R.D.3 (Myers District)</u>				d. STREET ADDRESS <u>Westminster, Md. R.D.3 (Myers Dist)</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wynamore Sylvester Stewart</u>				4. DATE OF DEATH Month Day Year <u>5/12/56</u> <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/19/1904</u>	
9. AGE (In years last birthday) yrs. <u>51</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>His own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Adams Co., Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frank Stewart</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Dull</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>220-34-6656</u>				17. INFORMANT <u>Mrs. Ruth S. Stewart</u> Address <u>Md.</u> <u>Mrs. Ruth S. Stewart, R. D. 3, Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolus</u> <u>416X</u> DUE TO <u>Myocarditis + aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease</u> (c) <u>20 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Westminster, Md.</u>				20g. (County) <u>Carroll</u>			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>12 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 May</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>13 May '56</u>							
ACTUAL SIGNATURE <u>Anthony G. Tanaris</u> M.D. <u>Mc Sherry, Pa.</u>							
PHYSICIAN'S NAME (Type) <u>Anthony G. Tanaris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kriders Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Westminster, Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>				ADDRESS <u>Littlestown, Pa.</u>		24a. REC'D BY REGISTRAR <u>5-15-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>							

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. SIGNATURE OF DECEASED [Faint text]</p>	
<p>10. SIGNATURE OF WITNESS [Faint text]</p>		<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JUDGE [Faint text]</p>		<p>15. SIGNATURE OF CLERK [Faint text]</p>	

BUREAU V. S.

MAY 16 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 174

5309

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5Y 4M 4 D</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		15-26-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Henry</b> Last <b>Suddueth</b>		4. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/77</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Weins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to decubitus ulcer</b> DUE TO (b) <b>Peripheral arteriosclerosis and Arteriosclerotic heart disease</b> DUE TO (c) <b>Right mid-thigh amputation on 3/27/56</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pernicious Anemia; Chronic brain syndrome associated with senile brain disease, psychotic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pernicious Anemia; Chronic brain syndrome associated with senile brain disease, psychotic</b>			
INTERVAL BETWEEN ONSET AND DEATH weeks years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/12</b> , 19 <b>56</b> to <b>5/7</b> , 19 <b>56</b> that I last saw the deceased alive on <b>5/7</b> , 19 <b>56</b> , and that death occurred at <b>10:29 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Walther H. Sonnenfeldt</b> M.D. <b>5/7/56</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. <b>Sykesville, Maryland</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-10-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>7557 Wisc Ave Bethesda</b>	
24a. REC'D BY REGISTRAR <b>C. J. Perry</b>		24b. REGISTRAR'S SIGNATURE <b>Walter</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 9 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES	
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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

050056

## 5010 CERTIFICATE OF DEATH

Reg. Dist. No. 33

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Einheburg</i>		LENGTH OF STAY (in this place) <i>2 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Owings Mills</i>		<i>038-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Einheburg Nursing Home</i>				STREET ADDRESS (If rural give location) <i>Garrison Rd.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <i>K Irene Tilyard</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>May 2 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>12-23-1869</i>	9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife for self.</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Phillip Tilyard</i>				14. MOTHER'S MAIDEN NAME <i>Virginia Ann Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Miss Dorothy Tilyard Hobbs 218 Baltimore Ave. Baltimore</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <i>PULMONARY EDEMA</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4-5 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>ARTERIOSCLEROTIC C.V. DISEASE</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>WITH CARDIAC DECOMPENSATION</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>APRIL 1952</i> , to <i>MAY 3, 1956</i> , that I last saw the deceased alive on <i>5/1/56</i> , 19 <i>56</i> , and that death occurred at <i>7:40 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Martin E. Stuebel</i>				ADDRESS (Street, city, town, state) <i>Reisterstown Md.</i>		DATE SIGNED <i>5/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 7-56</i>		NAME OF CEMETERY OR CREMATORY <i>St. Thomas</i>		LOCATION (City, town, or county) (State) <i>Owings Mills md</i>	
24. REC'D BY REGISTRAR DATE <i>4-4-56</i>		REGISTRAR'S SIGNATURE <i>Wm B. Elmer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Elmer</i> ADDRESS <i>Reisterstown Md</i>			



RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the day after the death, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05006

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>PHILA.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>4 MOS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILA.</u>		d. STREET ADDRESS <u>4726 N. MARVINE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COURT ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ZONE <u>41</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VICTOR</u> <u>ALFONZO</u> <u>VILCHES</u>				4. DATE OF DEATH Month Day Year <u>5</u> <u>18</u> <u>1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 30, 1902</u>			
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR-FOREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>FLA.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>LOUIS VILCHES</u>				14. MOTHER'S MAIDEN NAME <u>MARGARETA MOREJON</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>265-164077</u>		17. INFORMANT <u>COLETTE VILCHES</u> Address <u>4726 N. MARVINE PHILA. 41, PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging by the neck.</u> 9774X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged by his neck</u>					
20c. TIME OF INJURY Month, Day, Year <u>6</u> <u>5.18</u> <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>County jail</u>		20f. (City or town) (County) (State) <u>Westminster Carroll Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James J. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-21-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMORIAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BUCKS CO. PA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. BARNHARDT &amp; SON, WESTMINSTER, MD.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>5-20-56</u>			
						24b. REGISTRAR'S SIGNATURE <u>H. Gained Miller</u>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

MAY 23 1956

RECEIVED

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05007

## 5011 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH COUNTY <b>Carroll</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <b>Manchester, Md.</b> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>21 N. MAIN ST.</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Carroll</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Manchester, Md.</b> TOWN STREET ADDRESS (If rural give location) <b>21 North Main St</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Mary Alice Weaver</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>May 6 19 56</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>March 17, 1950</b>		9. AGE last birthday <b>6</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Eugene Weaver</b>				14. MOTHER'S MAIDEN NAME <b>Mary B. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or N.A.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Mrs Eugene Weaver Manchester, Md.</b>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
196x IMMEDIATE CAUSE (A) <b>Osteogenic Sarcoma</b>						<b>1 yr</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Metastatic lesions to lung</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 1950</b> to <b>May 6</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/6/56</b> , 19 <b>56</b> , and that death occurred at <b>11A</b> M., from the causes and on the date stated above.							
SIGNATURE <b>W. H. Flood</b> M.D.				ADDRESS (Street, city, town, state) <b>Manchester, Md.</b>		DATE SIGNED <b>5/6/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>MAY 9 56</b>		NAME OF CEMETERY OR CREMATORY <b>Emmanuel Lutheran Cemetery, Manchester, Md.</b>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <b>May 7-56</b>		REGISTRAR'S SIGNATURE <b>Mrs. W. P. Sommer</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Myers, Jr. Westminster Md.</b>		ADDRESS	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

NAME OF DECEASED Mary E. Jones		SEX Female		AGE 45	
PLACE OF BIRTH Boston, Mass.		DATE OF BIRTH Jan. 15, 1910		PLACE OF DEATH Boston, Mass.	
OCCUPATION Housewife		CAUSE OF DEATH Coronary thrombosis		MANNER OF DEATH Natural	
DATE OF DEATH May 10, 1956		TIME OF DEATH 10:30 A.M.		PLACE OF INTERMENT Mount Hope Cemetery	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME Jones & Sons		NAME OF BURIAL PLACE Mount Hope Cemetery	

**RECEIVED**  
 MAY 10 1956  
 BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5712

## CERTIFICATE OF DEATH

05008

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 month; 20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1818 E. 32nd St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Virginia Reeder Wise</b>		4. DATE OF DEATH Month Day Year <b>May 14 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/66</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Reeder</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Parker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary artery embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease, with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>  <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/10/56</b> , 19 <b>56</b> , to <b>5/14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/13</b> , 19 <b>56</b> , and that death occurred at <b>2:15 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland.</b> DATE SIGNED <b>5/14/56</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR DATE <b>5/16/56</b>	
ADDRESS <b>5305 Harford</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Fier</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 5712  
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
OCCASION OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PRESENT MARRIAGE [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
OCCASION OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX OF BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PRESENT MARRIAGE [Illegible]	

RECEIVED  
 MAY 16 1956  
 BUREAU V. S.

5713

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN lb <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>533 Camel Street</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Woods</b> Last <b>Woods</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 30, 1901</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roanoke, Va.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Samuel H. Woods</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Arrington</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>216-14-4022</b>				17. INFORMANT <b>James Woods - Patient</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral cavitory pulmonary TB</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <b>May 25, 1956</b> , to <b>May 27, 1956</b> , that I last saw the deceased alive on <b>May 27, 1956</b> , and that death occurred at <b>12.30A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. F. Vestal</b>				ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		DATE SIGNED <b>5-27-56</b>	
PHYSICIAN'S NAME (Type) <b>Tom F. Vestal, M. D., Supt.</b>				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-31-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Alburn Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adolphus Halstead</b>				ADDRESS <b>918 W. Hill</b>		24a. REC'D BY REGISTRAR <b>5/28/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert R. Swankhaus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05010

5714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Silver Run) Rural, Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Silver Run) Rural, Westminster</b>	
c. LENGTH OF STAY IN b. <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.1</b>		d. STREET ADDRESS <b>Westminster, Md. R.D.1</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>S.</b> Last <b>Yingling</b>		4. DATE OF DEATH Month <b>5/22/56</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/1871</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min. <b>84</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>	11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Adam P. Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Almedia Burgoon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Mary E. Yingling</b> Address <b>Mrs. Mary E. Yingling, R.D.1, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 ACUTE CORONARY OCCLUSION</b> DUE TO (b) <b>5 MIN.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>5 MIN.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-30, 1955</b> , to <b>5-22, 1956</b> , that I lost saw the deceased olive on <b>2-22, 1956</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Littlestown, Pa.</b> DATE SIGNED <b>5-22-56</b> ACTUAL SIGNATURE <b>L. L. Potter</b> M.D. PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/25/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b> ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR <b>DATE 5-24-56</b>	24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 1-c FilmG201 8-15-56 et  
5015  
CERTIFICATE OF DEATH

05011

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>32 yrs. 11 mths</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keasington ?</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				d. STREET ADDRESS <b>10408 Muir Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>G.</b> Last <b>Zimmerman</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 14, 1884.</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John D. Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Marth Valentine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT (niece) <b>Mrs. Roger Zimmerman Walkersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General paralysis of the insane</b> <b>025 x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>33</b> , to <b>May 30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 30</b> , 19 <b>56</b> , and that death occurred at <b>11.55 a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				DATE SIGNED <b>May 30, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2 June 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. C. Barton, Walkersville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>June 2/1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Zickel</b>	

1956 4 JUN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5016

## CERTIFICATE OF DEATH

Reg. Dist. No.

05012  
17

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville, Md.</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore-6</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-6</b> d. STREET ADDRESS <b>4258 Nicholas Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ZIMMERMAN</b> Last <b>N</b>		4. DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>19 56</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/79</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b>19</b> Min. <b>56</b>	IF UNDER 24 HRS. Months <b>7</b> Days <b>16</b> Hours <b>19</b> Min. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Polisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silverware</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Zimmerman n</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>216-10-0231</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic cancer of the lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of the prostate gland</b> DUE TO (c) <b>Psychotic depression</b>						INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/9/56</b> , 19 <b>56</b> , to <b>5/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/16</b> , 19 <b>56</b> , and that death occurred at <b>12:40A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Walther H. Sonnenfeldt</b> <b>Springfield State Hospital 5/16/56</b>						
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		M.D. <b>Springfield State Hospital 5/16/56</b>				
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M. D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 17/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore term</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip H. Hargis</b>		ADDRESS <b>2024 Orleans St</b>		24a. REC'D BY REGISTRAR <b>18 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Steers</b>

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BUREAU V.